Part D Complaint Intake Form

CMS KCRO/Division of Medicare Operations

Complainant Information:

Name:

Phone Number:

Address:

City:

State: **Zip:**

Email:

Beneficiary Information:

Name: **Medicare Number**:

Phone Number: **Date of Birth**:

Address:

City:

State: **Zip**:

Email:

Plan Name:

State Where Beneficiary Enrolled:

Date of Incident:

Nature of the Complaint:

Information Received By:

Name: **Date:**

NOTE: DO NOT SEND THIS FORM VIA E-MAIL TO ENSURE CONFIDENTIALITY OF INDIVIDUAL'S PERSONAL INFORMATION IS PROTECTED.

Fax to (816) 426-7604.